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CHALENG 2005 Survey: VA Pittsburgh HCS, PA (VAMC Pittsburgh (HD) - 646A5 and VAMC Pittsburgh (UD) - 646)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 319

2. Estimated Number of Veterans who are Chronically Homeless: 77

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 319 (estimated number of homeless veterans in service area) **x chronically homeless rate (24 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	650	30
Transitional Housing Beds	748	25
Permanent Housing Beds	373	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	At this year's CHALENG meeting, presenters invited and collaborated with out county. Information offered on VA Grant and Per Diem, Section 8 and other HUD housing. Continued efforts and collaboration VA and community resources should assist with veteran
Immediate shelter	Presently, the HCHV team is actively involved with establishing an "engagement center" shelter in the city with community providers.
Help finding a job or getting employment	Every effort is made to work with veterans in finding a job or getting employment. There is a vocational rehabilitation specialist/MSW who works with veterans. She is part of the HCHV team.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: 64   **Non-VA staff Participants: 75.0%**
Homeless/Formerly Homeless: 14.1%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.30	3.0%	3.47
Food	3.79	7.0%	3.80
Clothing	3.61	5.0%	3.61
Emergency (immediate) shelter	3.16	25.0%	3.33
Halfway house or transitional living facility	3.20	20.0%	3.07
Long-term, permanent housing	2.91	34.0%	2.49
Detoxification from substances	3.33	15.0%	3.41
Treatment for substance abuse	3.50	18.0%	3.55
Services for emotional or psychiatric problems	3.5	12.0%	3.46
Treatment for dual diagnosis	3.3	20.0%	3.30
Family counseling	3.13	3.0%	2.99
Medical services	3.82	5.0%	3.78
Women's health care	3.32	2.0%	3.23
Help with medication	3.31	7.0%	3.46
Drop-in center or day program	3.25	12.0%	2.98
AIDS/HIV testing/counseling	3.43	2.0%	3.51
TB testing	3.48	2.0%	3.71
TB treatment	3.50	.0%	3.57
Hepatitis C testing	3.47	.0%	3.63
Dental care	3.21	12.0%	2.59
Eye care	3.27	.0%	2.88
Glasses	3.16	7.0%	2.88
VA disability/pension	3.57	3.0%	3.40
Welfare payments	3.51	2.0%	3.03
SSI/SSD process	3.45	.0%	3.10
Guardianship (financial)	3.17	2.0%	2.85
Help managing money	3.17	7.0%	2.87
Job training	3.42	10.0%	3.02
Help with finding a job or getting employment	3.37	22.0%	3.14
Help getting needed documents or identification	3.43	2.0%	3.28
Help with transportation	3.12	5.0%	3.02
Education	3.23	8.0%	3.00
Child care	2.89	7.0%	2.45
Legal assistance	3.02	7.0%	2.71
Discharge upgrade	3.11	2.0%	3.00
Spiritual	3.52	3.0%	3.36
Re-entry services for incarcerated veterans	2.76	12.0%	2.72
Elder Healthcare	3.21	5.0%	3.06

* % of site participants who identified this need as one of the top three they would like to work on now.
**VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site Mean Score (non-VA respondents only)
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.24
Co-location of Services - Services from the VA and your agency provided in one location.	2.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.17
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.08
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.86
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.11
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.14
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.03
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.67
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.80
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.64

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site Mean Score (non-VA respondents only)
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.67
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.49

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CHALENG 2005 Survey: VAM&ROC Wilmington, DE - 460

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 500

2. Estimated Number of Veterans who are Chronically Homeless: 25

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 500 (estimated number of homeless veterans in service area) **x chronically homeless rate (5 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	251	50
Transitional Housing Beds	108	31
Permanent Housing Beds	252	113

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	A previously identified need, current plan is in place and will continue.
Dental care	Expand use of homeless veteran dental services with coordination with Atlanti-Care Health Services. Address need with Philadelphia VAMC which has patients housed at Atlantic City Rescue Mission. Dental Services are 65 miles away from Atlantic County.
Treatment for substance abuse	A plan is in place and continues. HCHV acts as a conduit for homeless veterans from local services to VA substance abuse treatment.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: 12   **Non-VA staff Participants: 91.7%**
Homeless/Formerly Homeless: **16.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.33	.0%	3.47
Food	4.25	.0%	3.80
Clothing	4.00	.0%	3.61
Emergency (immediate) shelter	4.00	9.0%	3.33
Halfway house or transitional living facility	2.33	27.0%	3.07
Long-term, permanent housing	2.42	55.0%	2.49
Detoxification from substances	3.17	9.0%	3.41
Treatment for substance abuse	3.17	27.0%	3.55
Services for emotional or psychiatric problems	3.8	9.0%	3.46
Treatment for dual diagnosis	3.4	.0%	3.30
Family counseling	3.27	.0%	2.99
Medical services	3.92	18.0%	3.78
Women's health care	3.73	.0%	3.23
Help with medication	3.42	.0%	3.46
Drop-in center or day program	3.20	9.0%	2.98
AIDS/HIV testing/counseling	4.08	.0%	3.51
TB testing	4.08	.0%	3.71
TB treatment	3.50	.0%	3.57
Hepatitis C testing	3.73	.0%	3.63
Dental care	1.83	36.0%	2.59
Eye care	2.50	9.0%	2.88
Glasses	2.75	9.0%	2.88
VA disability/pension	3.20	.0%	3.40
Welfare payments	3.64	9.0%	3.03
SSI/SSD process	3.25	9.0%	3.10
Guardianship (financial)	2.75	18.0%	2.85
Help managing money	2.67	9.0%	2.87
Job training	3.18	17.0%	3.02
Help with finding a job or getting employment	3.25	9.0%	3.14
Help getting needed documents or identification	3.08	.0%	3.28
Help with transportation	3.00	9.0%	3.02
Education	3.17	.0%	3.00
Child care	2.83	.0%	2.45
Legal assistance	3.17	8.0%	2.71
Discharge upgrade	2.91	.0%	3.00
Spiritual	3.67	.0%	3.36
Re-entry services for incarcerated veterans	3.08	.0%	2.72
Elder Healthcare	3.17	9.0%	3.06

* % of site participants who identified this need as one of the top three they would like to work on now.
**VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site Mean Score (non-VA respondents only)
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.18
Co-location of Services - Services from the VA and your agency provided in one location.	2.55
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.82
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.64
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.27
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.45
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.09
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.64
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.27
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.36
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.73

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site Mean Score (non-VA respondents only)
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.55
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.73

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CHALENG 2005 Survey: VAMC Altoona, PA - 503

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 10

2. Estimated Number of Veterans who are Chronically Homeless: 1

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 10 (estimated number of homeless veterans in service area) **x chronically homeless rate (13 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	234	10
Transitional Housing Beds	10	0
Permanent Housing Beds	30	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

	Community Action of Blair County and Family Services are working together to develop a men's homeless emergency shelter.
Transitional living facility or halfway house	Working with local agencies to create a safe place for the homeless person until a more permanent plan can be created.
Help finding a job or getting employment	Hopefully this VAMC will get a CWT program to assist the homeless veterans to learn a skill to get a job.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: 18   **Non-VA staff Participants**: 88.9%
Homeless/Formerly Homeless: .0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.00	.0%	3.47
Food	3.65	12.0%	3.80
Clothing	3.65	6.0%	3.61
Emergency (immediate) shelter	3.18	65.0%	3.33
Halfway house or transitional living facility	2.81	35.0%	3.07
Long-term, permanent housing	2.87	12.0%	2.49
Detoxification from substances	3.65	.0%	3.41
Treatment for substance abuse	3.59	.0%	3.55
Services for emotional or psychiatric problems	3.4	6.0%	3.46
Treatment for dual diagnosis	3.5	.0%	3.30
Family counseling	3.24	.0%	2.99
Medical services	4.00	6.0%	3.78
Women's health care	3.63	6.0%	3.23
Help with medication	3.50	12.0%	3.46
Drop-in center or day program	2.75	6.0%	2.98
AIDS/HIV testing/counseling	3.40	.0%	3.51
TB testing	3.53	.0%	3.71
TB treatment	3.47	.0%	3.57
Hepatitis C testing	3.87	12.0%	3.63
Dental care	2.73	12.0%	2.59
Eye care	3.12	.0%	2.88
Glasses	3.18	.0%	2.88
VA disability/pension	4.07	.0%	3.40
Welfare payments	3.63	.0%	3.03
SSI/SSD process	3.33	.0%	3.10
Guardianship (financial)	3.21	.0%	2.85
Help managing money	2.93	12.0%	2.87
Job training	3.06	24.0%	3.02
Help with finding a job or getting employment	2.88	29.0%	3.14
Help getting needed documents or identification	3.40	.0%	3.28
Help with transportation	3.25	18.0%	3.02
Education	3.24	6.0%	3.00
Child care	3.00	.0%	2.45
Legal assistance	3.13	.0%	2.71
Discharge upgrade	3.47	.0%	3.00
Spiritual	3.43	.0%	3.36
Re-entry services for incarcerated veterans	3.00	18.0%	2.72
Elder Healthcare	3.50	6.0%	3.06

* % of site participants who identified this need as one of the top three they would like to work on now.
**VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site Mean Score (non-VA respondents only)
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.08
Co-location of Services - Services from the VA and your agency provided in one location.	1.62
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.31
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.83
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.92
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.92
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.09
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.80
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.73
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.82

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site Mean Score (non-VA respondents only)
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.79
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.93

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CHALENG 2005 Survey: VAMC Butler, PA - 529

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 55

2. Estimated Number of Veterans who are Chronically Homeless: 37

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 55 (estimated number of homeless veterans in service area) **x chronically homeless rate (67 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	8	5
Transitional Housing Beds	18	5
Permanent Housing Beds	5	5

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Expand education and awareness of the homeless condition by increasing agency networking and developing partnerships to address homeless issues in order to address immediate shelter needs.
Long-term, permanent housing	Use community resources and VA Per Diem grant money to obtain permanent housing.
Transportation	Develop rural transportation network.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: 43   **Non-VA staff Participants**: 81.0%
Homeless/Formerly Homeless: 4.7%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.33	3.0%	3.47
Food	3.95	6.0%	3.80
Clothing	3.57	9.0%	3.61
Emergency (immediate) shelter	3.18	47.0%	3.33
Halfway house or transitional living facility	3.50	12.0%	3.07
Long-term, permanent housing	3.15	25.0%	2.49
Detoxification from substances	3.62	3.0%	3.41
Treatment for substance abuse	3.82	6.0%	3.55
Services for emotional or psychiatric problems	3.7	18.0%	3.46
Treatment for dual diagnosis	3.6	21.0%	3.30
Family counseling	3.66	6.0%	2.99
Medical services	4.03	15.0%	3.78
Women's health care	3.80	.0%	3.23
Help with medication	3.65	3.0%	3.46
Drop-in center or day program	3.51	.0%	2.98
AIDS/HIV testing/counseling	3.53	3.0%	3.51
TB testing	3.64	.0%	3.71
TB treatment	3.72	.0%	3.57
Hepatitis C testing	3.77	.0%	3.63
Dental care	3.05	18.0%	2.59
Eye care	3.45	.0%	2.88
Glasses	3.49	.0%	2.88
VA disability/pension	3.84	6.0%	3.40
Welfare payments	3.66	3.0%	3.03
SSI/SSD process	3.68	6.0%	3.10
Guardianship (financial)	3.27	6.0%	2.85
Help managing money	3.13	9.0%	2.87
Job training	3.58	15.0%	3.02
Help with finding a job or getting employment	3.64	21.0%	3.14
Help getting needed documents or identification	3.65	.0%	3.28
Help with transportation	3.21	18.0%	3.02
Education	3.38	9.0%	3.00
Child care	3.03	3.0%	2.45
Legal assistance	2.95	3.0%	2.71
Discharge upgrade	3.47	3.0%	3.00
Spiritual	3.75	3.0%	3.36
Re-entry services for incarcerated veterans	3.08	9.0%	2.72
Elder Healthcare	3.57	9.0%	3.06

* % of site participants who identified this need as one of the top three they would like to work on now.
**VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site Mean Score (non-VA respondents only)
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.59
Co-location of Services - Services from the VA and your agency provided in one location.	1.87
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.91
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.25
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.48
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.69
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.38
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.16
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.09
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.78
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.68
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.97

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site Mean Score (non-VA respondents only)
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.91
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.75

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CHALENG 2005 Survey: VAMC Clarksburg, WV - 540

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 20

2. Estimated Number of Veterans who are Chronically Homeless: 3

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 20 (estimated number of homeless veterans in service area) **x chronically homeless rate (17 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	37	0
Transitional Housing Beds	1	10
Permanent Housing Beds	60	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Assist Scott Place Shelter with moving forward on their plan to purchase adjoining property to build transitional living facility. Also to transition veterans under contract into Scott Place if they are an appropriate candidate. Continue to provide case
Dental care	Try to work my outside resources in organization pro bono dental assistance through dental providers. Also to involve a new MSW student to try to work with a local school of dentistry.
Immediate shelter	A shelter in Grafton is being pursued at this time. This shelter will cover a more rural population. I will continue to work with the Monvalley continue of care and assists in moving this process forward.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: 30   **Non-VA staff Participants**: **85.7%**
Homeless/Formerly Homeless: **6.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.96	4.0%	3.47
Food	4.21	9.0%	3.80
Clothing	3.74	4.0%	3.61
Emergency (immediate) shelter	3.77	26.0%	3.33
Halfway house or transitional living facility	2.81	35.0%	3.07
Long-term, permanent housing	2.46	21.0%	2.49
Detoxification from substances	3.56	13.0%	3.41
Treatment for substance abuse	3.60	9.0%	3.55
Services for emotional or psychiatric problems	3.5	4.0%	3.46
Treatment for dual diagnosis	3.2	.0%	3.30
Family counseling	3.09	.0%	2.99
Medical services	3.81	21.0%	3.78
Women's health care	3.75	4.0%	3.23
Help with medication	3.75	4.0%	3.46
Drop-in center or day program	2.70	17.0%	2.98
AIDS/HIV testing/counseling	3.54	4.0%	3.51
TB testing	4.08	.0%	3.71
TB treatment	3.95	.0%	3.57
Hepatitis C testing	3.86	4.0%	3.63
Dental care	2.55	38.0%	2.59
Eye care	3.04	4.0%	2.88
Glasses	3.07	4.0%	2.88
VA disability/pension	3.64	4.0%	3.40
Welfare payments	3.04	.0%	3.03
SSI/SSD process	3.46	.0%	3.10
Guardianship (financial)	3.00	4.0%	2.85
Help managing money	3.18	.0%	2.87
Job training	3.27	4.0%	3.02
Help with finding a job or getting employment	3.08	9.0%	3.14
Help getting needed documents or identification	3.22	4.0%	3.28
Help with transportation	3.15	17.0%	3.02
Education	3.28	4.0%	3.00
Child care	2.64	4.0%	2.45
Legal assistance	2.52	9.0%	2.71
Discharge upgrade	3.32	4.0%	3.00
Spiritual	3.92	.0%	3.36
Re-entry services for incarcerated veterans	2.73	9.0%	2.72
Elder Healthcare	3.55	4.0%	3.06

* % of site participants who identified this need as one of the top three they would like to work on now.
**VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site Mean Score (non-VA respondents only)
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.50
Co-location of Services - Services from the VA and your agency provided in one location.	2.10
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.80
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.55
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.45
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.60
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.16
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.63
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.47
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.63
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.82

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site Mean Score (non-VA respondents only)
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.50

CHALENG 2005 Survey: VAMC Coatesville - 542

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1015

2. Estimated Number of Veterans who are Chronically Homeless: 223

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1015 (estimated number of homeless veterans in service area) **x chronically homeless rate (22 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	2082	100
Transitional Housing Beds	669	100
Permanent Housing Beds	262	200

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	VA will continue its commitment to provide outpatient services for veterans residing in permanent housing. Staff will also educate and encourage participation in all HUD housing programs. Impact Services will continue its pursuit of providing the first
Dental care	VA along with other agencies will continue to communicate about low-cost, community dental programs and make appropriate referrals.
Job training	VA is currently hiring Supported Employment staff to assists the seriously mentally ill in finding employment and providing ongoing coaching. All agencies will continue to refer veterans to the Department of Labor programs.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: 59   **Non-VA staff Participants: 34.5%**
Homeless/Formerly Homeless: 8.5%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.69	.0%	3.47
Food	4.04	4.0%	3.80
Clothing	3.96	2.0%	3.61
Emergency (immediate) shelter	3.49	13.0%	3.33
Halfway house or transitional living facility	3.20	19.0%	3.07
Long-term, permanent housing	2.28	68.0%	2.49
Detoxification from substances	3.81	4.0%	3.41
Treatment for substance abuse	3.86	6.0%	3.55
Services for emotional or psychiatric problems	3.5	13.0%	3.46
Treatment for dual diagnosis	3.5	4.0%	3.30
Family counseling	2.84	8.0%	2.99
Medical services	3.71	2.0%	3.78
Women's health care	3.50	8.0%	3.23
Help with medication	3.61	.0%	3.46
Drop-in center or day program	3.21	4.0%	2.98
AIDS/HIV testing/counseling	3.77	.0%	3.51
TB testing	3.86	.0%	3.71
TB treatment	3.69	.0%	3.57
Hepatitis C testing	3.89	.0%	3.63
Dental care	2.44	37.0%	2.59
Eye care	2.83	8.0%	2.88
Glasses	2.78	2.0%	2.88
VA disability/pension	3.48	4.0%	3.40
Welfare payments	3.47	.0%	3.03
SSI/SSD process	3.39	2.0%	3.10
Guardianship (financial)	3.13	2.0%	2.85
Help managing money	3.02	12.0%	2.87
Job training	3.28	17.0%	3.02
Help with finding a job or getting employment	3.46	10.0%	3.14
Help getting needed documents or identification	3.39	2.0%	3.28
Help with transportation	2.84	8.0%	3.02
Education	2.86	6.0%	3.00
Child care	2.40	13.0%	2.45
Legal assistance	2.60	4.0%	2.71
Discharge upgrade	3.04	.0%	3.00
Spiritual	3.62	6.0%	3.36
Re-entry services for incarcerated veterans	2.98	10.0%	2.72
Elder Healthcare	3.23	4.0%	3.06

* % of site participants who identified this need as one of the top three they would like to work on now.
**VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site Mean Score (non-VA respondents only)
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.42
Co-location of Services - Services from the VA and your agency provided in one location.	1.84
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.78
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.06
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.67
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.50
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.06
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.78
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.56
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.56
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.39

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site Mean Score (non-VA respondents only)
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.21
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.42

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VAMC Erie, PA - 562

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 24

2. Estimated Number of Veterans who are Chronically Homeless: 7

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 24 (estimated number of homeless veterans in service area) **x chronically homeless rate (31 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	178	0
Transitional Housing Beds	10	2
Permanent Housing Beds	22	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 7

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Set up meeting with Director of Housing Authority to discuss housing needs. Homeless coalition is working on a public service announcement to run on television.
Job training	Contacted local employment Agency, Career Links, to discuss current employment needs and type of education needed to meet criteria. A team from local homeless coalition will contact local unions to discuss methods of job training and preparation.
Help finding a job or getting employment	Introduce homeless to methods and manner to use computer systems to search for work. Post positions that become available in places like Vet Centers. Demonstrate/teach interview ring techniques, assist in preparing resumes, offer follow-up support.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: 16   **Non-VA staff Participants: 62.5%**
Homeless/Formerly Homeless: 18.8%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.69	.0%	3.47
Food	4.06	6.0%	3.80
Clothing	4.00	6.0%	3.61
Emergency (immediate) shelter	4.00	13.0%	3.33
Halfway house or transitional living facility	3.75	6.0%	3.07
Long-term, permanent housing	2.67	44.0%	2.49
Detoxification from substances	3.73	13.0%	3.41
Treatment for substance abuse	4.19	.0%	3.55
Services for emotional or psychiatric problems	4.3	6.0%	3.46
Treatment for dual diagnosis	3.9	6.0%	3.30
Family counseling	3.50	13.0%	2.99
Medical services	4.19	13.0%	3.78
Women's health care	3.50	13.0%	3.23
Help with medication	4.06	6.0%	3.46
Drop-in center or day program	4.31	.0%	2.98
AIDS/HIV testing/counseling	4.07	.0%	3.51
TB testing	4.27	.0%	3.71
TB treatment	4.20	.0%	3.57
Hepatitis C testing	4.19	.0%	3.63
Dental care	2.63	13.0%	2.59
Eye care	2.81	.0%	2.88
Glasses	2.86	.0%	2.88
VA disability/pension	4.13	13.0%	3.40
Welfare payments	3.38	.0%	3.03
SSI/SSD process	3.42	6.0%	3.10
Guardianship (financial)	3.29	13.0%	2.85
Help managing money	3.38	13.0%	2.87
Job training	2.94	38.0%	3.02
Help with finding a job or getting employment	3.27	19.0%	3.14
Help getting needed documents or identification	4.00	6.0%	3.28
Help with transportation	3.93	6.0%	3.02
Education	3.13	.0%	3.00
Child care	2.85	19.0%	2.45
Legal assistance	2.73	.0%	2.71
Discharge upgrade	3.21	.0%	3.00
Spiritual	3.36	.0%	3.36
Re-entry services for incarcerated veterans	3.07	6.0%	2.72
Elder Healthcare	3.53	6.0%	3.06

* % of site participants who identified this need as one of the top three they would like to work on now.
**VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site Mean Score (non-VA respondents only)
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.00
Co-location of Services - Services from the VA and your agency provided in one location.	2.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.89
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.44
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.44
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.22
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.67
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.44
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.33
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.50
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.38

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site Mean Score (non-VA respondents only)
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.80
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.40

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CHALENG 2005 Survey: VAMC Lebanon, PA - 595

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 196

2. Estimated Number of Veterans who are Chronically Homeless: 57

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 196 (estimated number of homeless veterans in service area) **x chronically homeless rate (29 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	364	100
Transitional Housing Beds	336	30
Permanent Housing Beds	147	30

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Work with homeless coalitions to advocate with community and city and state government to make this a priority.
Dental care	Work with community health clinics to apply for funding to supply dental care. Work with homeless coalitions and agencies to advocate for state dental funding.
Re-entry services for incarcerated veterans	Work with homeless coalitions to: (1) bring awareness to state government and community municipalities, (2) form coalitions to apply for funding, and(3) work with faith-based agencies to apply for funding and to restructure their admission criteria.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: 25   **Non-VA staff Participants: 95.8%**
Homeless/Formerly Homeless: .0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.39	5.0%	3.47
Food	3.95	.0%	3.80
Clothing	3.73	.0%	3.61
Emergency (immediate) shelter	3.38	14.0%	3.33
Halfway house or transitional living facility	3.50	18.0%	3.07
Long-term, permanent housing	2.71	45.0%	2.49
Detoxification from substances	3.76	5.0%	3.41
Treatment for substance abuse	4.00	.0%	3.55
Services for emotional or psychiatric problems	3.8	14.0%	3.46
Treatment for dual diagnosis	3.8	.0%	3.30
Family counseling	3.33	.0%	2.99
Medical services	3.48	5.0%	3.78
Women's health care	3.60	9.0%	3.23
Help with medication	3.13	13.0%	3.46
Drop-in center or day program	3.00	14.0%	2.98
AIDS/HIV testing/counseling	4.05	.0%	3.51
TB testing	3.59	.0%	3.71
TB treatment	3.41	.0%	3.57
Hepatitis C testing	3.74	5.0%	3.63
Dental care	2.52	23.0%	2.59
Eye care	3.09	14.0%	2.88
Glasses	3.09	.0%	2.88
VA disability/pension	3.96	.0%	3.40
Welfare payments	3.71	.0%	3.03
SSI/SSD process	3.60	5.0%	3.10
Guardianship (financial)	2.62	13.0%	2.85
Help managing money	2.73	17.0%	2.87
Job training	3.17	18.0%	3.02
Help with finding a job or getting employment	3.22	5.0%	3.14
Help getting needed documents or identification	3.43	9.0%	3.28
Help with transportation	3.50	18.0%	3.02
Education	3.55	.0%	3.00
Child care	3.00	5.0%	2.45
Legal assistance	3.05	9.0%	2.71
Discharge upgrade	3.37	.0%	3.00
Spiritual	3.50	.0%	3.36
Re-entry services for incarcerated veterans	2.81	26.0%	2.72
Elder Healthcare	2.89	9.0%	3.06

* % of site participants who identified this need as one of the top three they would like to work on now.
**VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site Mean Score (non-VA respondents only)
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.83
Co-location of Services - Services from the VA and your agency provided in one location.	1.81
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.45
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.50
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.52
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.41
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.33
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.65
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.53
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.45
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.40
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.45

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site Mean Score (non-VA respondents only)
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.17
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	2.91

CHALENG 2005 Survey: VAMC Philadelphia, PA - 642

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 550

2. Estimated Number of Veterans who are Chronically Homeless: 105

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 550 (estimated number of homeless veterans in service area) **x chronically homeless rate (19 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	2500	150
Transitional Housing Beds	96	45
Permanent Housing Beds	22	35

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 12

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	We continue to need more long-term, permanent, affordable housing for our veterans. We have increased our contacts with private citizens willing to rent to our veterans. We need affordable housing for our NSC pensioners.
Guardianship	We must have a better, more connected relationship with SSA in order to break the cycle of homelessness. VA funds are managed well and we have a great relationship with them. SSA is another story.
Help managing money	VA does have a guardianship unit which is helpful, but case managers on the ground need to micromanage the funds for rent, clothes, food, etc.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: 67   **Non-VA staff Participants: 62.9%**
Homeless/Formerly Homeless: **7.5%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.23	3.0%	3.47
Food	3.65	8.0%	3.80
Clothing	3.28	3.0%	3.61
Emergency (immediate) shelter	3.59	15.0%	3.33
Halfway house or transitional living facility	3.03	20.0%	3.07
Long-term, permanent housing	2.43	40.0%	2.49
Detoxification from substances	3.52	7.0%	3.41
Treatment for substance abuse	3.62	8.0%	3.55
Services for emotional or psychiatric problems	3.7	18.0%	3.46
Treatment for dual diagnosis	3.4	14.0%	3.30
Family counseling	2.92	3.0%	2.99
Medical services	4.00	5.0%	3.78
Women's health care	3.46	7.0%	3.23
Help with medication	3.56	5.0%	3.46
Drop-in center or day program	3.23	10.0%	2.98
AIDS/HIV testing/counseling	3.66	.0%	3.51
TB testing	3.66	.0%	3.71
TB treatment	3.56	.0%	3.57
Hepatitis C testing	3.68	.0%	3.63
Dental care	2.70	10.0%	2.59
Eye care	2.89	.0%	2.88
Glasses	2.86	2.0%	2.88
VA disability/pension	3.37	10.0%	3.40
Welfare payments	3.43	2.0%	3.03
SSI/SSD process	3.21	3.0%	3.10
Guardianship (financial)	2.87	7.0%	2.85
Help managing money	2.70	17.0%	2.87
Job training	2.73	15.0%	3.02
Help with finding a job or getting employment	2.56	19.0%	3.14
Help getting needed documents or identification	2.95	3.0%	3.28
Help with transportation	2.97	10.0%	3.02
Education	2.83	7.0%	3.00
Child care	2.53	.0%	2.45
Legal assistance	2.75	7.0%	2.71
Discharge upgrade	2.87	2.0%	3.00
Spiritual	3.17	7.0%	3.36
Re-entry services for incarcerated veterans	2.51	12.0%	2.72
Elder Healthcare	3.16	2.0%	3.06

* % of site participants who identified this need as one of the top three they would like to work on now.
**VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site Mean Score (non-VA respondents only)
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.46
Co-location of Services - Services from the VA and your agency provided in one location.	1.49
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.91
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.31
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.74
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.66
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.89
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.11
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.14
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.74
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.56
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.80

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site Mean Score (non-VA respondents only)
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.53
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.36

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CHALENG 2005 Survey: VAMC Wilkes-Barre, PA - 693

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 522

2. Estimated Number of Veterans who are Chronically Homeless: 42

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 522 (estimated number of homeless veterans in service area) **x chronically homeless rate (8 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	160	0
Transitional Housing Beds	35	0
Permanent Housing Beds	40	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Will continue to work with Community agencies, Housing Development Corps and our local housing authorities to advocate for the need for additional permanent housing units for our homeless veterans.
Transportation	Work with local transportation authority to inquire about discounted fares and seek monetary coverage in obtaining bus tokens.
Immediate shelter	Work with local faith-based emergency shelters in rural counties.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: 57   **Non-VA staff Participants**: **91.1%**
Homeless/Formerly Homeless: **1.8%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.54	5.0%	3.47
Food	4.11	5.0%	3.80
Clothing	4.00	5.0%	3.61
Emergency (immediate) shelter	3.89	20.0%	3.33
Halfway house or transitional living facility	3.40	18.0%	3.07
Long-term, permanent housing	2.89	36.0%	2.49
Detoxification from substances	3.54	7.0%	3.41
Treatment for substance abuse	3.56	7.0%	3.55
Services for emotional or psychiatric problems	3.7	14.0%	3.46
Treatment for dual diagnosis	3.6	9.0%	3.30
Family counseling	3.44	2.0%	2.99
Medical services	4.11	7.0%	3.78
Women's health care	3.25	9.0%	3.23
Help with medication	3.43	7.0%	3.46
Drop-in center or day program	3.51	2.0%	2.98
AIDS/HIV testing/counseling	3.81	5.0%	3.51
TB testing	3.68	.0%	3.71
TB treatment	3.68	.0%	3.57
Hepatitis C testing	3.69	2.0%	3.63
Dental care	3.02	18.0%	2.59
Eye care	3.04	5.0%	2.88
Glasses	2.98	4.0%	2.88
VA disability/pension	3.79	4.0%	3.40
Welfare payments	3.70	.0%	3.03
SSI/SSD process	3.43	7.0%	3.10
Guardianship (financial)	3.05	5.0%	2.85
Help managing money	2.95	5.0%	2.87
Job training	2.89	16.0%	3.02
Help with finding a job or getting employment	2.95	13.0%	3.14
Help getting needed documents or identification	3.18	4.0%	3.28
Help with transportation	2.96	23.0%	3.02
Education	2.93	5.0%	3.00
Child care	2.82	4.0%	2.45
Legal assistance	2.81	9.0%	2.71
Discharge upgrade	3.30	2.0%	3.00
Spiritual	3.68	2.0%	3.36
Re-entry services for incarcerated veterans	2.95	11.0%	2.72
Elder Healthcare	3.54	5.0%	3.06

* % of site participants who identified this need as one of the top three they would like to work on now.
**VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	Site Mean Score (non-VA respondents only)
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.74
Co-location of Services - Services from the VA and your agency provided in one location.	2.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.13
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.26
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.55
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.60
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.91
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.45
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.11
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.53
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.68
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.77

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site Mean Score (non-VA respondents only)
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.85
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.88